

# Learning from Standardised Reviews When Babies Die – 2020 Annual Report



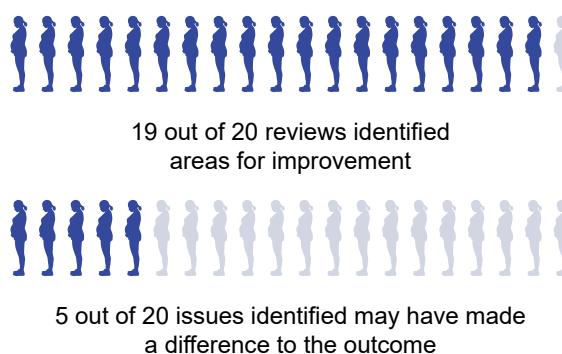
Key Messages – October 2021

Since the launch of the national Perinatal Mortality Tool (PMRT) in early 2018 over 14,000 reviews have been started. This third annual report presents the findings for reviews completed from March 2020 to February 2021 coinciding with the first year of the SARS-CoV-2 global pandemic. Here are the key messages from the 3,981 reviews completed during this period.

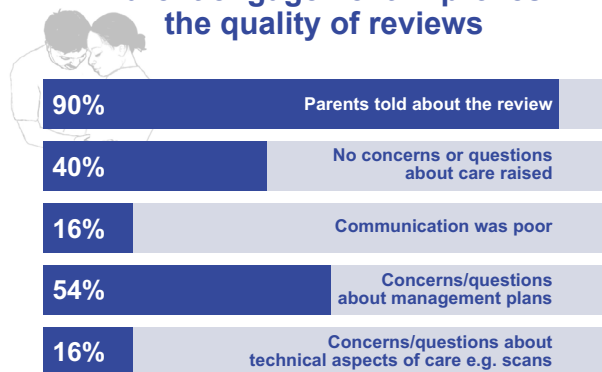
## Multi-disciplinary group review is essential



## Issue with care and areas for improvement identified at review



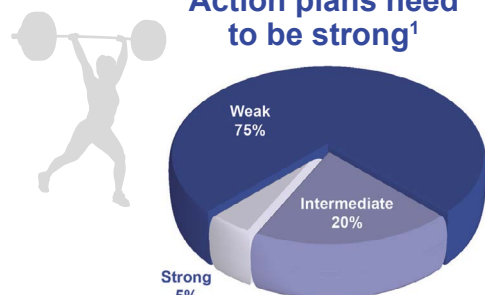
## Parent engagement improves the quality of reviews



## Comments, question and concerns raised by parents



## Action plans need to be strong<sup>1</sup>



1. Strong actions are system changes which remove the reliance on individuals to choose the correct action. They use standardised and permanent physical or digital designs to eliminate human error and are sometimes referred to as 'forcing actions'.
2. Artificial rupture of membranes
3. Electronic patient record

## Examples of the strength<sup>1</sup> of actions planned

<p><b>Weak</b></p> <p>“Distribute communication to maternity staff regarding the necessity for intrapartum antibiotics in preterm labour and the importance of this.”</p> <p>A reminder for individual action without any controls</p>	<p><b>Intermediate</b></p> <p>“Major review which led to a new staffing model and a newly appointed Lead for Triage and Induction.”</p> <p>A new system in place but still requires individuals to act without any controls</p>	<p><b>Strong</b></p> <p>“Process for assessing need for aspirin developed and implemented via EPR<sup>2</sup>”</p> <p>A system level electronic design to eliminate human error</p>
--	---	---